STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155252	A. BUILDING 00 B. WING	11/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-WOODLANDS	4088 FRAME RD NEWBURGH, IN47630

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F0000	This visit was for the Investigation of Complaint IN00099128. Complaint IN00099128 Substantiated, Federal/State deficiencies related to the allegations are cited at F157, F250, and F329. Survey dates: November 21 and 22, 2011 Facility number: 000155 Provider number: 155252 AIM number: 100266830 Survey team: Anne Marie Crays RN Census bed type: SNF/NF: 106 Total: 106 Census payor type: Medicare: 11 Medicaid: 74 Other: 21 Total: 106 Sample: 7 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	**Plan of Correction:** *Preparation and submission of this Plan Of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and 19 programs, and to provide the best possible care to our residents as possible.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 11/28/11 Cathy Emswiller RN			

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to ensure the physician was notified of residents' weight loss and/or the dietician's recommendations, for 3 of	F0157	**F157** **The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:** R# A, B and D, RD recommendations were reviewed and implemented and MDs notified as indicated.	12/22/2011

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	3 residents reviewed for weight loss, in a sample of 7. Resident B, Resident D, Resident A Findings include: 1. On 11/21/11 at 8:50 A.M., during the initial tour, the Social Service Director indicated Resident B had been losing weight. The clinical record of Resident B was reviewed on 11/21/11 at 10:30 A.M. Diagnoses included, but were not limited to, Closed fracture of the femur, Chronic Obstructive Pulmonary Disease, and Psychosis. A Progress Note, dated 9/23/11 at 3:47 P.M., indicated, "Dietician's Note: Significant change assessment of nutritional status D/T [due to] recent return from hospital...Regular diet with PO [by mouth] intake averaging 36% past seven days...To augment PO intake, recommend Two Cal supplement 60cc BID [twice daily]...." Documentation indicating the physician was notified of the dietician's recommendation was lacking in the clinical record. A monthly weight record, dated 10/20/11,		**Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:** Residents with weight loss had medical records reviewed, recommendations implemented as indicated, MDs and families notified. **The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:**Nursing staff will be inserviced by 12/22/11 on notification of physician, family, and resident when a weight loss occurs and any recommendations from the Dietitian at that time will be reviewed. Unit manager, Dining services manager, and Director of Nursing/Designee will receive all Dietitian recommendations. Dining services manager will check recommendations for completion and review any outstanding recommendations in the morning clinical start-up meeting with the clinical team. Director of nursing or designee will review weight loss and Dietitian recommendations daily and audit for notification of changes. **These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:** DNS/Designee will review the	

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	indicated the resident's weight was 85.2#. Documentation indicating the physician was notified of the resident's weight loss was lacking in the clinical record. A Physician's note, dated 11/4/11, indicated, "...Poor appetite...." A Progress Note, dated 11/17/11 at 2:31 P.M., indicated, "Resident weight 73.2#, significant weight loss noted...." Documentation indicating the physician was notified of the resident's further weight loss was lacking in the clinical record. On 11/22/11 at 10:10 A.M., during interview with the Dietary Manager [DM] and Administrator, the DM indicated the dietician makes recommendations and emails those recommendations to the DM, Administrator and the Nursing Unit Managers. The Unit Managers then contact the physician. The Administrator indicated Dietary then should follow up. On 11/22/11 at 2:40 P.M., the Administrator indicated she could not find additional information that the physician was notified of the recommendation or the resident's weight loss. 2. On 11/21/11 at 8:50 A.M., during the initial tour, the Social Service Director		results of the audits and any concerns will be reported at monthly QA meetings for 6 months unless further monitoring is deemed necessary at that time. The data will be analyzed for patterns and trends and action plans will be written and implemented as needed. Corrections will be completed by December 22, 2011.	

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	indicated Resident D had been losing weight. The clinical record of Resident D was reviewed on 11/22/11 at 10:00 A.M. Diagnoses included, but were not limited to, Alzheimer's Disease. A Physician's order, dated 7/19/11 and on the current November 2011 orders, indicated, "Supplement: 2 cal Supplement 60cc PO [by mouth] TID [three times daily] a day everyday." A Progress Note, dated 9/26/11 at 5:45 P.M., indicated, "Dietician's Note:...Noted to have significant 10% weight loss x 180 days with Mar [March] weight of 156.8# to Sep [September] weight of 141.1#. Supplemented with Two Cal, 60cc TID...Recommend increase Two Cal to 90cc PO TID...." Documentation indicating the physician was notified of the dietician's recommendation or the weight loss was lacking in the clinical record. On 11/22/11 at 2:40 P.M., during interview with the Administrator, she indicated she had no further information regarding physician notification. 3. On 11/21/11 at 8:50 A.M., during the			

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	initial tour, the Social Services Director indicated Resident A had been losing weight. The clinical record of Resident A was reviewed on 11/21/11 at 1:00 P.M. Diagnoses included, but were not limited to, Presenile Dementia. Progress Notes, dated 9/8/11 at 12:19 P.M., indicated, "...Current weight 115 down from 123. 9% weight loss...." Progress Notes, dated 10/28/11 at 3:44 P.M., indicated, "Resident weight down 5% x 1 month, weekly weight monitoring and weight meeting. Dietician to review next visit...." Documentation regarding physician notification of the weight loss was lacking in the clinical record. On 11/22/11 at 2:40 P.M., during interview with the Administrator, she indicated she had no further information regarding physician notification of the weight loss. 4. On 11/22/11 at 3:00 P.M., the Administrator provided the current facility policy on "Notification of Change in Resident Health Status," undated. The policy included: "The center will consult			

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	the resident's physician, nurse practitioner or physician assistant...when there is:...(B) Acute illness or a significant change in the resident's physical, mental, or psychosocial status (i.e. deterioration in health...)...(C) A need to alter treatment significantly (i.e. a need to...commence a new form of treatment)...Depending on the nursing assessment appropriate notification may be immediate to 48 hours...." This federal tag relates to Complaint IN00099128. 3.1-5(a)(1)			

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F0250 SS=D	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to develop and revise interventions to manage a resident's behavior [Resident A], and failed to develop a therapeutic work plan, including supervision, for Resident E, for 2 of 5 residents reviewed for psychosocial well-being, in a sample of 7. Resident A, Resident E Findings include: 1. On 11/21/11 at 8:50 A.M., during the initial tour, RN # 1 indicated Resident A had wandering behaviors. Resident A was observed to be sleeping at that time. The clinical record of Resident A was reviewed on 11/21/11 at 1:00 P.M. Diagnoses included, but were not limited to, Presenile Dementia. A Minimum Data Set [MDS] assessment, dated 10/5/11, indicated Resident A had a short-term and long-term memory problem and was moderately impaired in cognitive skills for daily decision-making. The MDS assessment indicated Resident A had no behavior symptoms, including	F0250	**F250** **The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:**Resident A care plan interventions were individualized and updated. Resident E therapy work program was reevaluated. A meeting was held with Resident E, ED, SSD and DSM. His contract was reviewed with him. Resident E was reeducated on his volunteer duties. The Activity Director/Designee will be responsible for directing, observing, supervising and evaluating resident E's volunteer chores. An evaluation with resident E will occur every thirty days via behavior/activity monitoring sheet. His POA was notified. **Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:** Facility residents have had care plans reviewed been updated as needed. **The measures put into place and the systemic changes made to ensure that this deficient**	12/22/2011

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	wandering. A Care Plan, dated 10/14/11, indicated a problem of "I have little or no awareness of safety, or boundaries related to other's personal space aeb [as evidenced by] Wandering about my living space, Going into other resident's rooms, Rummaging through items that aren't mine and Not always aware if areas are okay for me to be in." The Interventions included: "If I'm pacing/wandering throughout my living space, I may be looking for a bathroom...Invite me to participate in activities that remind me of things I enjoy doing...Offer me opportunities for social interaction and visiting with others...Place 1-1 with staff or family as necessary 10/15/11, Attempt activities such as folding towels...Offer a snack...." The interventions were not updated since 10/15/11. Progress Notes included the following notations: 10/16/11 at 8:08 A.M.: "...Staff was unable to contain the res. as she was walking into other res. rooms, and unable to sleep..." 10/16/11 at 1:23 P.M.: "Patient up ad lib ambulating about unit has had to be redirected out of other patients rooms		**practice does not recur are as follows:** The Social Services Director will review and update all care plans on residents that have wandering. Monthly behavior management meetings will be held with the Unit Manager, Social Service Director and Activity staff attending. Resident A will be reviewed in behavior meeting weekly x 4 then bi-weekly x4 weeks and then monthly thereafter. Resident E will be observed 5x per week x 1 week and then twice per week x 4 weeks and then weekly will be evaluated by the Activity Department or designee. Any residents doing resident oriented activities i.e. passing menus, passing mail will be monitored weekly by activity staff or designee. **These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following** ED/DNS/Designee will review the results of the audits and any concerns will be reported at monthly QA meetings for 6 months unless further monitoring is deemed necessary at that time. The data will be analyzed for patterns and trends and action plans will be written and implemented as needed Corrective actions will be in place by 12/22/11.	

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	numerous times...." 10/17/11 at 5:36 A.M.: "...The res. [resident] had a difficult time settling down and was seen wandering into res. rooms, touching med cart cups and going into laundry carets. Interventions attmeps [sic] consisited [sic], redirection, offered food, drink, CNA talking to her, and other activities. The resident was restless...She was given Ativan [an anti-anxiety medication] and was escorted to there bed...." 10/17/11 at 10:36 A.M.: "Over the weekend, resident continued to be up ad lib and walking throughout the unit and was restless during the night...Resident is usually easily redirected and likes to keep busy. [Resident A] has dx [diagnosis] of dementia and is often confused as to where she is or what she should be doing and staff should anticpate [sic] her needs and keep her active...." 10/17/11 at 6:54 P.M.: "It was reported to SSD [social service director] that last night after residents were put to bed, CNA heard someone calling out down the hallway. CNA went to room and as she was walking in she saw [Resident A] in another resident's room hovering over her in bed. Resident took her call light and struck [Resident A's] upper chest area			

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	with it...Care conference with family was held...in agreement to send [Resident A] to [psychiatric hospital] for medication adjustment...[Psychiatric hospital] will be in around 8am tomorrow to assess...." 10/18/11 at 10:24 A.M.: "Another resident reported that this morning around 6am, [Resident A] came into his room, sat on his bed, removed her clothing, and made an inappropriate statement. He told her to get out, at which time she did leave. Currently [Resident A's] son is here sitting 1-1 with her...." 10/19/11 at 10:16 A.M.: "[Psychiatric hospital] reported that her insurance denied her to be admitted to hospital...Resident is currently on 1-1 with staff or family." 10/23/11 at 8:05 P.M.: "Resident up and ambulating in hallway most of day going in and out of other residents rooms. Other residents becoming upset. resident redirected multiple times but would go right back into other residents rooms again [sic] after just a few minutes...." 10/28/11 at 7:13 A.M.: "At 0600 [6:00 A.M.] this am resident gout out of her bed...A few minutes later resident jerked a blanket from another resident's lap...."			

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	11/1/11 at 3:16 A.M.: "Res. on 1:1 all night. She was redirected constantly from going into other res. rooms...." 11/5/11 at 3:44 P.M.: "Resident up wandering facility most of day requiring staff to follow her in and out of other residents room...." 11/6/11 at 1:31 P.M.: "...Resident in and out of rooms today upsetting other residents. Resident difficult to redirect at times...." 11/9/11 at 4:09 P.M.: "Has been wandering around facility most of the day. Is difficult to redirect...has had to have one on one supervision." 11/17/11 at 1:07 P.M.: "Res has been supervised by 1 or more staff at all times...Staff unable to redirect successfully...She wanders the halls...observed wandering into other res rooms, attempts to disrobe often...." 11/20/11 at 5:21 P.M.: "Resident up and wandering in hallway going into other residents room. Other residents getting upset at resident. Staff attempting to redirect resident and resident become [sic] upset and started hitting and kicking at staff. PRN [as needed] Ativan given per order. Resident continues to wander and			

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	going into other residents rooms after IM ativan given...." On 11/21/11 at 11:50 A.M., during an interview with Resident F, she indicated there "were a couple of other residents" who would wander into her room uninvited. Resident F named Resident A, and indicated, "I had to hide my tapes because she would mess with them." On 11/21/11 at 11:55 A.M., during an interview with Resident G, she indicated, "Oh, yes" regarding any residents who wandered into her room uninvited. Resident G named Resident A, and indicated, "My roommate can't stand her. About a month ago, we woke up during the night, and [Resident A] was under my roommate's bed. She had my pink shawl, that was on my bed, around her." On 11/22/11 at 9:00 A.M., during interview with the Social Services Director [SSD], she indicated Resident A had started wandering in October. The SSD indicated she had a care plan meeting with the family in October when the wandering started. The SSD indicated the facility had attempted different things in an attempt to redirect the resident. The SSD indicated the facility had "behavior meetings" every other month, which the pharmacist, unit manager, and herself			

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	discussed resident behaviors. The SSD could not recall if the most recent behavior meeting was in September or October. The SSD indicated the care plan had not been updated since October 15. 2. On 11/21/11 at 9:25 A.M., Resident E, who was wearing a volunteer name tag and was distributing menus, was observed to take down a "Stop" sign attached across a resident's door with velcro, and enter without knocking. Resident E was then observed to enter 4 other resident rooms without knocking. CNA # 1 indicated at that time who the resident was. RN # 2 was passing medications at that time in the same hallway. On 11/21/11 at 9:40 A.M., RN # 3 indicated Resident E lived on the other unit and was a resident volunteer who "helped dietary by picking up menus and doing other jobs." On 11/21/11 at 10:10 A.M., during interview with the Dietary Manager [DM] and Administrator, the Administrator indicated Resident E did jobs around the facility, such as cleaning tables and delivering menus. The DM indicated she was not the person responsible for directing Resident E. The Administrator indicated, "Probably Social Services." The Administrator indicated the resident was			

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GOLDEN LIVING CENTER-WOODLANDS	4088 FRAME RD NEWBURGH, IN47630

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	not allowed to push other residents in their chairs, that "that was an issue in the past." The clinical record of Resident E was reviewed on 11/22/11 at 10:55 A.M. Diagnoses included, but were not limited to, Schizophrenia. A care plan, initially dated 4/18/11 and updated 10/20/11, indicated a problem of "I'm pretty independent in participating in my favorite activities, including volunteering. At most I need help with newer or more complex programs." The interventions included: "May do therapeutic chores as desired by resident." An additional care plan, initially dated 6/29/11 and updated 10/20/11, indicated a problem of "I believe that I am in charge at times and feel I can supervise the other residents and staff. Removed residents hand from rail [and] pushed down hall." The interventions included: "Remind him of his volunteer work he likes - refer to activities, dietary manager. 9/20/11 Educate [Resident E] not to intervene with other residents. 10/20/11 Meeting with [Resident E] and family." Progress notes indicated the following notations:			

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	10/15/11 at 8:38 P.M.: "...SSD discussed with him that it was reported that he moved a resident that was in hallway. Discussed with him that he is not to move residents...." 10/20/11 at 2:20 P.M.: "...He volunteers per his choice with therapeutic chores such as assisting with cleaning tables after parties and meals...." 10/20/11 at 3:00 P.M.: "Conference held this date with [Resident E], sister [name], Administrator and SSD. Reviewed 'Contract for [Resident E]' which lists what behaviors are not allowed. Contract states that his actions affect the other residents, staff and his own safety. Discussed for him to continue to do volunteer at facility [sic] he must adhere to contract. Discussed that if he fails to follow contract he will not be allowed to continue to do volunteer activities...." A "Contract for [name of Resident E]" included the following: "...Do not enter other residents room without knocking and being told it is OK to enter...." On 11/22/11 at 1:45 P.M., during interview with the SSD and Administrator regarding Resident E's therapeutic work, the SSD indicated, "The activities director is more involved with that." The			

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	Administrator indicated, "Activities is the supervisor, and if there are issues, then Social Service would be involved." The Administrator indicated, "Activities pretty much assigns the tasks." On 11/22/11 at 2:15 P.M., during interview with the Activities Director [AD], the AD indicated the resident "likes to stay busy." The AD indicated Resident E "helps with selective menus." The AD indicated she "drops in on him from time to time." 3. On 11/22/11 at 3:00 P.M., the Administrator provided the current facility policy on "Behavior Management Guideline," revised January 2011. The policy included: "Purpose, To develop behavior plans and medication regimes, when appropriate, to optimize the functional abilities of all residents while monitoring for adverse outcomes...Observe resident for possible causes...Non-pharmacological interventions and implemented and assessed for effectiveness, PRIOR to considering initiation of any psychoactive medications...The Social Service Director coordinates in service education to all staff related to behavior management...care plan is developed for residents exhibiting negative behavior...."			

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	This federal tag is related to Complaint IN00099128. 3.1-34(a)			

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, interview, and record review, the facility failed to ensure adequate indications for the use of Ativan, an anti-anxiety medication, given for agitation, for 1 of 3 residents reviewed with psychotropic medications, in a sample of 7. Resident A Findings include: 1. On 11/21/11 at 8:50 A.M., during the initial tour, RN # 1 indicated Resident A	F0329	**F329** **The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:** Resident A's care plan was updated with individualized interventions by the Social Services Director. Medication list and medication regimen was reviewed by the physician with new orders received. The MDS was updated. Licensed nurses and the Unit Manager were in-serviced on using interventions prior to administering a prn antianxiety medication and documentation of those	12/22/2011

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	had behaviors of wandering. Resident A was observed lying in bed asleep at that time. On 11/21/11 at 9:30 A.M., LPN # 1 indicated Resident A "was our little behavior problem," and indicated staff let her sleep as long as she would. On 11/21/11 at 10:55 A.M., CNA # 2 and CNA # 3 indicated they were getting Resident A up. CNA # 2 and CNA # 3 indicated Resident A was "very difficult to direct." The clinical record of Resident A was reviewed on 11/21/11 at 1:00 P.M. Diagnoses included, but were not limited to, Depressive disorder and Presenile Dementia. A Physician's order, initially dated 6/29/11 and on the current November 2011 orders, indicated, "Lorazepam [Ativan] 0.5mg tablet by mouth Q [every] 4 hrs PRN [as needed] anxiety and agitation. Lorazepam...Admin 0.25mg IM Q4hrs PRN anxiety and agitation." A Minimum Data Set [MDS] assessment, dated 10/5/11, indicated the resident had a short-term and long-term memory problem and was moderately impaired in cognitive skills for daily decision-making.		attempted interventions. Weekly behavior management meeting will be held to discuss current behavior management program, care plan interventions and psychoactive medications. The Social Services Director, Unit Manager and Activity Director review the pharmacy reviews monthly. **Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:** Licensed nurses and the Unit Manager were in-serviced on using interventions prior to administering a prn antianxiety medication and documentation of those attempted interventions. Weekly behavior management meeting will be held to discuss current behavior management program, care plan interventions and psychoactive medications. The Social Services Director, Unit Manager and Activity Director review the pharmacy reviews monthly. **The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:** Licensed nurses and Unit Manager were in-serviced on interventions to be used prior to giving a PRN antianxiety medication and documentation of attempted interventions. PRN psychoactive medication use will be reviewed	

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	The MDS assessment indicated the resident had no behaviors. A Care Plan, dated 10/14/11, indicated a problem of "I have little or no awareness of safety, or boundaries related to other's personal space aeb [as evidenced by] Wandering about my living space, Going into other resident's rooms, Rummaging through items that aren't mine and Not always aware if areas are okay for me to be in." The Interventions included: "If I'm pacing/wandering throughout my living space, I may be looking for a bathroom...Invite me to participate in activities that remind me of things I enjoy doing...Offer me opportunities for social interaction and visiting with others...Place 1-1 with staff or family as necessary 10/15/11, Attempt activities such as folding towels...Offer a snack...." The interventions were not updated since 10/15/11. Progress Notes included the following notations: 10/16/11 at 8:08 A.M.: "...Staff was unable to contain the res. as she was walking into other res. rooms, and unable to sleep...Ativan was given...." 10/17/11 at 5:36 A.M.: "...The res. [resident] had a difficult time settling		during behavior management meetings monthly. Audit was completed on all residents receiving PRN psychoactive medications. Care plans will be updated with individualized interventions during the weekly behavior management meetings. Licensed nurses and the Unit Manager were in-serviced on using interventions prior to administering a prn antianxiety medication and documentation of those attempted interventions. The corrective actions will be monitored by the Director of Nursing Services or designee weekly for four weeks, then every other week for four weeks. **These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:** ED/DNS/Designee will review the results of the audits and any concerns will be reported at monthly QA meetings for 6 months unless continued monitoring is deemed necessary at that time. The data will be analyzed for patterns and trends and action plans will be written and implemented as needed Corrective actions will be in place by 12/22/11.	

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	down and was seen wandering into res. rooms, touching med cart cups and going into laundry carets. Interventions attmeps [sic] consisited [sic], redirection, offered food, drink, CNA talking to her, and other activities. The resident was restless...She was given Ativan [an anti-anxiety medication] and was escorted to her bed...." 10/27/11 at 12:09 P.M.: "Has had increased behaviors today prn ativan ineffective in managing anxiety...." 10/28/11 at 7:13 A.M.: "At 0600 [6:00 A.M.] this am resident gout out of her bed...A few minutes later resident jerked a blanket from another resident's lap...Resident became combative swing [sic] at staff...Resident was given her PRN Ativan at this time...." 11/1/11 at 3:16 A.M.: "Res. on 1:1 all night. She was redirected constantly from going into other res. rooms...Ativan was given and she went to bed half hour later." 11/3/11 at 11:08 A.M.: "...stated she was anxious unable to reassure verbally or with activitys [sic] or redirection PRN ativan effective in relieving anxiety...." 11/8/11 at 12:56 P.M.: "Resident up ambulating ad lib without difficulty			

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	wandering about unit became agitated with toileting and struck cna was noted to be anxious today redirection food fluid toileting ineffective PRN ativan was helpful in decreasing anxiety." 11/17/11 at 1:07 P.M.: "Res has been supervised by 1 or more staff at all times...Staff unable to redirect successfully...She wanders the halls...observed wandering into other res rooms, attempts to disrobe often...IM Ativan administered in left hip...." 11/20/11 at 5:21 P.M.: "Resident up and wandering in hallway going into other residents room. Other residents getting upset at resident. Staff attempting to redirect resident and resident become [sic] upset and started hitting and kicking at staff. PRN [as needed] Ativan given per order. Resident continues to wander and going into other residents rooms after IM ativan given...." The resident's November 2011 Medication Administration Record [MAR] was reviewed. The MAR indicated the resident received Ativan 32 times for "aggitation [sic] and anxiety" from 11/1/11 through 11/22/11. The pre-printed "non-pharmalogical interventions" included: Food/fluids, Toileting, Repositioning, Quiet			

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	environment, Deep breathing, Reassurance and Dim lighting. On 11/22/11 at 9:30 A.M., during interview with the SSD and Administrator, the SSD indicated behavior meetings are held every other month with the pharmacist, the unit manager and herself. The SSD indicated PRN medications were not discussed in the behavior meetings. The SSD indicated she did not know who tracked how often the resident was receiving the prn Ativan. The SSD and Administrator indicated they had tried different interventions with the resident. 2. On 11/22/11 at 3:00 P.M., the Administrator provided the current facility policy on "Behavior Management Guideline," revised January 2011. The policy included: "...Non-pharmacological interventions and implemented and assessed for effectiveness, PRIOR to considering initiation of any psychoactive medications...Each resident's drug regimen will be free from unnecessary drugs...." This federal tag relates to Complaint IN00099128. 3.1-48(a)(4)			

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